Table 1. Comparison of clinical and laboratory findigs of patients with and without fQRS

	fQRS present (n=91)	fQRS absent (n=157)	p value
Age	64,82±12,65	62,26±11,38	0,102
Sex M/F	69/22	120/37	0,914
Hypertension (%)	48 (52,7)	72 (45,9)	0,296
Diabetes Mellitus (%)	21 (23,1)	29 (18,5)	0,384
Hyperlipidemia (%)	27 (29,7)	32 (20,4)	0,098
Cigarette habit (%)	55 (60,4)	92 (58,6)	0,776
Family history (%)	29 (31,9)	40 (25,5)	0,279
Chest pain duration (min)	194,62±174,01	165,19±171,51	0,196
SBP (mmHg)	132,81±26,56	128,15±26,22	0,181
DBP (mmHg)	79,32±17,01	76,73±16,91	0,248
Door to needle time (min)	29,11±9,43	26,90±8,08	0,181
LVEF (%)	34,83±6,76	46,75±6,22	<0,001
HB (gr/dl)	13,23±1,93	13,47±2,04	0,355
WBC (x103/μL)	12.958±3.07	10.780±3.38	<0,001
PLT (x103/μL)	227,89±63,43	217,78±71,74	0,266
BUN (mg/dl)	19,24±13,72	17,48±6,18	0,248
Creatinine (mg/dl)	1,00±0,48	0,94±0,35	0,202
LDL-chol (mg/dl)	121,79±31,06	121,96±31,11	0,968
HDL-chol (mg/dl)	36,78±9,54	38,10±9,74	0,311
Maximum CK-MB (ng/ml)	228,27±121,23	114,77±85,55	<0,001
Maximum Troponin (ng/ml)	62,73±53,49	29,71±16,17	<0,001
QRS duration (msn)	107,86±8,95	102,77±9,21	<0,001
MI localization Anterior MI (%) Other (%)	35 (38,5) 56 (61,5)	71 (45,2) 86 (54,8)	0,300

(SBP: systolic blood pressure, DBP: diastolic blood pressure, LVEF: left ventricular ejection fraction, HB: hemoglobin, WBC: white blood cell count, MPV: mean platelet volume, PLT: platelet count, BUN: blood urea nitrogen, LDL-chol: low density lipoprotein-cholesterol, HDL-chol: high density lipoprotein-cholesterol, CK-MB: creatinine kinase-muscle band, MI: myocardial infarction)

POSTERS

PP-327

Abstract Withdrawn

PP-328

Feasibility of GRACE and TIMI Scores in Predicting the Extension of Coronary Artery Disease in Patients with Non ST Elevation Myocardial Infarction

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Aım: To assess the correlation of TIMI and GRACE risk scores with the SYNTAX score as the surrogate of severity and extent of coronary artery disease in patients with non-ST segment elevation myocardial infarction (NSTEMI).
Materıals-Methods: Patients admitted to our emergency department with chest pain, meeting the criteria of NSTEMI and undergoing coronary angiography during hospitalisation were considered for this study. Patients with ST segment elevation at admission, new left bundle branch block, percutaneous coronary intervention in the previous 6 months or previous coronary artery bypass graft surgery were excluded. TIMI and GRACE risk scores were calculated and coronary artery disease severity and extension were assessed by an experienced invasive cardiologist using the SYNTAX score algorithm.
Results: We assessed 145 patients (mean age 59.41±11.04 years, 29% female). A positive correlation of the SYNTAX score was observed with GRACE scores for in-hospital death, in-hospital death or MI, death at 6 month and death or MI at 6 month (r=0,414, p<0.0001; r=0,370, p<0.0001; r=0,417, p<0.0001; r=0,415, p<0.0001, respectively). The SYNTAX score also had a significant but weaker correlation with the TIMI score(r=0,271, p=0.001). The GRACE score showed good discriminatory capacity between the patients with and without a high-risk (>33) SYNTAX score, with an area under the ROC curve of 0.804 (CI 0.660–0.948, p=0.002); however, the TIMI score showed no predictive capacity and had an area under the ROC curve of 0.532 (CI 0.358–0.749, p=0.749).
Conclusıon: There is a positive association between GRACE, TIMI scores and SYNTAX score in patients with NSTEMI. GRACE scores but not TIMI score can predict the patients with high risk SYNTAX score (>33).

PP-329

Exercise ECG Test Should be Evaluated with Troponin T after Exercise in Women with an Intermediate Pretest Probability

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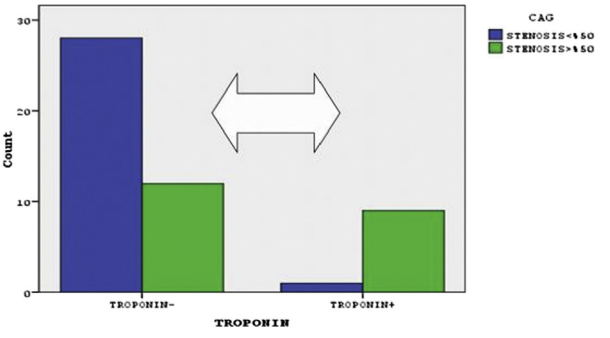
Background: A variety of tests are available to establish the diagnosis of coronary heart disease. Coronary angiography is the definitive diagnostic test for the presence of obstructive coronary artery disease. However, it is seldom used as the initial test because of its invasive nature.More practice exercise ECG testing is most useful in patients with an intermediate pretest probability (variably defined as between 25 and 75 percent or between 10 and 90 percent). But diagnosing coronary artery disease is more difficult with exercise ECG test in women with an intermediate pretest probability, because accurancy of exercise ECG is low. So we aimed to increase PPV (positive predictive value) of exercise ECG test together with used troponin T at fourth hour after exercise in women with an intermediate pretest probability.
Material-Methods: The study group for the evaluation of the diagnostic value of positive exercise ECG test and troponin T at fourth hour comprised 50 female patients with an intermediate pretest probability. The average age of the patients was 46.08±4.1. All the patients underwent ECG stress test, and all of them also coronary angiography as the next stage of the CAD definitive diagnosis process. During the test their clinical condition, ECG and arterial pressure were monitored. All the patients had positive exercise ECG test results. Additionally, the maximum pulse rate (MPR), number of the achieved metabolic equivalents (MET), stage and reason for termination, if any, were analysed. The degree of coronary stenosis was assessed visually and greater than 50% stenosis of the luminal diameter were considered haemodynamically significant (at any coronary). Troponin T was evaluated in all patient at fourth hour after exercise ECG test. Troponin>0.04 pg/ml was approved positive.
Results: The PPV of only exercise ECG test was 42% in women with an intermediate pretest probability. The PPV of exercise ECG test with troponin T(+) for positive coronary angiography (requirement revascularization at any coronary) was 90%, with troponin T(-) for positive coronary angiography was 30%. If compared, exercise ECG test with troponin T(+) was a better diagnostic predictor of CHD(coronary heart disease) was required revascularization (p<0.001).
Conclusıons: Exercise ECG test with troponin T(+) is superior to exercise ECG test with troponin T(-) in the prediction of necessary revascularisation procedures in women with an intermediate pretest probability and positive stress test results.



PP-330

Relation of Mean Platelet Volume with Subclinical Atherosclerosis in Patients with Metabolic Syndrome

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Objectıve: Metabolic syndrome (MetS) is associated with increased cardiovascular morbidity and mortality. There is evidence of platelet activation in MetS. Mean platelet volume (MPV), a determinant of platelet activation, is a newly emerging risk factor for atherothrombosis. Therefore, we have investigated the possible association between subclinical atherosclerosis,e valuated by carotid intima-media thickness (CIMT) measurement and MPV in MetS patients.
MATERIAL/METHODS:: 74 patients with MetS were enrolled to the study. Patients were divided into 2 groups according to CIMT measurement: 35 patients with CIMT ≥1,0 mm were at group 1 and 39 patients with CIMT <1,0 mm were at group 2. MPV were measured using an automated blood cell counter.